Summary of Provisions Affecting Medicaid and SCHIP in the Patient Protection and Affordable Care Act (P.L. 111-148) as Amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)

April 23, 2010 Draft

TITLE I— QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle E—Affordable Coverage Choices for All Americans

Section 1413 – Streamlining of Procedures for Enrollment Through an Exchange and State Medicaid, CHIP, and Health Subsidy Programs

Directs HHS to establish a system where individuals can apply for Medicaid, CHIP, tax credits for individual coverage through the exchange, or a State Basic Health Program for Residents Ineligble for Medicaid (created under the authority of Section 1331). The system must ensure that if individuals who are eligible for Medicaid or CHIP apply for tax credits in the exchange, they are enrolled Medicaid/CHIP instead.

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

Section 2001 – Medicaid Coverage for the Lowest Income Populations

Eligibility

Creates a mandatory eligibility group that expands Medicaid to 133% of Federal Poverty Level (FPL) for all individuals, without regard to categorical eligibility, effective January 1, 2014. Excludes people who are eligible for Medicaid through another mandatory eligibility group, who are entitled to Medicare Part A (regardless of whether they are enrolled) or who are enrolled in Medicare Part B. *Sec. 1004 of the Reconciliation Bill amends this group to include an income disregard based on the dollar amount of 5% of the 133% FPL level.*

The Bill also increases the mandatory income eligibility level for children age 6-19 to 133% FPL; these individuals are funded with the State's regular FMAP.

Allows states the option to expand coverage to the 133% FPL group earlier, beginning April 1, 2010 (*as amended by Section 10201*). States that expand prior to 2014 have the option to phase-in coverage, provided that individuals with higher incomes are not covered prior to individuals with lower incomes and that parents do not receive coverage unless their children are covered. Prior to 2014, states would receive their normal FMAP for individuals covered through the 133% group. Additionally, because this is an "expanded group," states would not receive the higher FMAP from the American Recovery and Reinvestment Act for this population.

Additionally, States have the option to expand coverage above 133% of FPL up to the highest income eligibility level in the State's Medicaid program (either through the State plan or a waiver). If a state chooses to expand beyond 133% FPL, it can phase-in coverage based on either income level or categorical groups. However, the state must provide coverage to individuals with lower income before it expands coverage to individuals with higher income within the same category.

States that allow presumptive eligibility under Section 1920 or 1920A may provide presumptive eligibility for the 133% group or for individuals eligible through Section 1931.

Services

The service package for the 133% group is the Benchmark Benefits Packages, created by the DRA, as defined by Section 1937 of the Social Security Act. States would not receive funding for services provided beyond those included in the Benchmark Benefits Package. Some individuals who enroll in the 133% group are excluded from the Benchmark Packages, such as individuals with disabilities, and would receive full Medicaid Benefits. On January 1, 2014, Benchmark plans are expanded to include the essential health benefits package defined in Section 1302 of the Act, and are required to have mental health parity. The "essential health benefits package" will be defined by HHS, but it must include at least:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Section 2303 of the act also requires Benchmark plans to offer family planning services, effective upon bill enactment.

Funding

Provides increased Federal Medical Assistance Percentage (FMAP) to cover the costs of the newly eligible individuals. *Sec. 1201 of the reconciliation bill (H.R. 4872) modifies the FMAP provisions to the final policies described in this document.* States will receive the following FMAP for "newly eligible individuals" (defined as individuals older than 19 who are not eligible for Medicaid through the state plan or a waiver on the date of the bill's enactment):

Calendar Year	**FMAP for Newly Eligibles**
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and beyond	90%

Defines expansion states as states with existing coverage for parents and non-pregnant childless adults with incomes up to at least 100% FPL that provides more benefits than premium assistance, hospital-only benefits, a high deductible plan, or health opportunity accounts. The bill gradually reduces expansion states' share of costs for individuals described in the 133% group that the state covered prior to the act. The formula for the reduction in state share is based upon the calendar year FMAP for newly Eligibles, and the "Transition Percentage" for that year. The formula is:

New FMAP = (State's Base FMAP) + [(Transition Percentage) x (FMAP for Newly Eligibles – State's Base FMAP)]

The Transition Percentage for each year is:

Calendar Year	Transition Percentage
2014	50%
2015	60%
2016	70%
2017	80%
2018	90%
2019 and beyond	100%

As an example, the 2015 FMAP for individuals in an expansion state with 54% FMAP that enroll in the 133% group would become:

New FMAP = (State's Base FMAP) + ((Transition Percentage) x (FMAP for Newly Eligibles – State's Base FMAP))
New FMAP = (54) + ((.60) x (100 - 54))
New FMAP = 81.6%

Maintenance of Effort
States are not permitted to have eligibility standards, methodologies, or procedures under the Medicaid State plan or through any waiver that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver in effect on the date of enactment. The maintenance of eligibility lasts until the establishment of the exchanges for adults, or until October 1, 2019 for children. Between January 1, 2011 and December 31, 2013, states that have expanded coverage to non-pregnant, non-disabled adults above 133% FPL can reduce the FPL to 133% if they certify that the state is experiencing a budget deficit. States can also transition individuals from waivers to the state plan, or can expand coverage, during the period when the "maintenance of eligibility" is in effect.

Annual Report
States are required to submit annual reports on Medicaid enrollment, broken out by different eligibility categories and populations. States must also identify newly enrolled individuals, and a description of outreach activities. The Secretary may also require additional reporting to monitor enrollment and retention.

Section 2002 – Income Eligibility for Nonelderly Determined Using Modified Gross Income (As Modified by Sec. 1004 of the Reconciliation Act)

Beginning January 1, 2014, the bill requires State Medicaid agencies to use "Modified Adjusted Gross Income" to determine eligibility for most Medicaid beneficiaries. MAGI is defined as "adjusted gross income increased by any amount excluded from gross income under section 911, and any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax." States will be prohibited from applying income disregards when determining eligibility, premiums or cost-sharing (except for the income disregard included in Sec. 1004 of the Reconciliation bill). The MAGI will also be used to determine premium and cost-sharing requirements. Requires states to establish an "equivalent income test" to make sure that no individuals lose eligibility due to the transition to MAGI and allows HHS to waive provisions of Title 19 (Medicaid) and 21 (CHIP) of the Social Security Act in order to implement the equivalent income test. If an individual does lose eligibility due to the elimination of disregards or the transition to MAGI, the person is grandfathered into Medicaid until the later of March 31, 2014 or the next regularly scheduled eligibility redetermination. The bill also prohibits states from applying asset tests when determining eligibility of individuals.

Excludes the following groups from the MAGI, and allows states to apply income disregards and asset tests to individuals in these groups:

- Individuals eligible for Medicaid through another program, such as SSI, Child Welfare, or another program that establishes Medicaid eligibility external to the Medicaid agency;
- Individuals age 65 and older;
- Individuals who are eligible for Medicaid because of blindness or a disability;
- Individuals eligible for Medicaid as "Medically Needy"; and
- Individuals eligible for Medicare Cost Sharing (Medicare Savings Plan).

Also excluded from MAGI and the asset removal provisions are determinations of eligibility for Long-term Care, and State determinations of eligibility for Medicare premium and cost-sharing subsidies under section 1860D–1 of the Social Security Act. The State may also rely on the findings of an "express lane agency" to determine eligibility for Medicaid.

Section 2003 – Requirement to Offer Premium Assistance for Employer-Sponsored Insurance

Section 2003 (as amended by Section 10203) amends Section 1906A to permit states to offer premium assistance and wrap-around benefits to all Medicaid beneficiaries, when it is cost-effective to do so[1]. Individuals are not required to enroll in employer-sponsored plans and can disenroll from coverage at any time. Section 1906A requires states to pay premium and cost sharing amounts that exceed the limits placed on premiums and nominal cost-sharing in Medicaid.

[1] Sec. 2003 requires states to offer premium assistance; Sec. 10203 strikes the language creating the requirement and retains the policy as a state option.

Section 2004 – Medicaid Coverage for Former Foster Care Children

Section 2004 (as amended by Section 10201) establishes a new mandatory categorical eligibility group, effective January 1, 2014. This group is comprised of individuals who are under age 26; who are not eligible for Medicaid through another mandatory eligibility group (except for the 133% expansion); and who were in foster care and enrolled in Medicaid on the day that they turned 18 (or the day that the individual turned whatever age individuals age out of foster care in the state). This group is exempt from mandatory enrollment in Medicaid Benchmark Benefits packages. Furthermore, if an individual simultaneously qualifies for this group and for the 133% expansion group, the state must enroll them into this categorical group.

Section 2005 Payments to Territories

Increases the spending caps for the territories by 30 percent and the applicable FMAP by five percentage points – to 55 percent – beginning on January 1, 2011 and for each fiscal year thereafter. Beginning in 2014, payments made to the territories with respect to amounts expended for medical assistance for newly eligible individuals would not count against the spending caps.

Section 2006 Special Adjustment for FMAP Determination for Certain States Recovering from a Major Disaster

Reduces projected decreases in Medicaid funding for States that have experienced major, statewide disasters.

Section 2007 Medicaid Improvement Fund Rescission

Rescinds $700 million available from 2014 – 2018 for "Medicaid Improvement" – including contractor oversight and demonstration project evaluation

Subtitle B- Enhanced Support for the Children's Health Insurance Program

Section 2101 Additional Federal Financial Participation for CHIP

Extends the current reauthorization period of CHIP for two years, through 9/30/15.

States would be required to maintain income eligibility levels for CHIP through September 30, 2019. From fiscal year 2016 to 2019, States would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent.

After October 1, 2013, the enrollment bonus payments for children ends.

Children who can't enroll in the Children's Health Insurance Program (CHIP) because allotments are capped are deemed ineligible for CHIP and, therefore, eligible for tax credits in the exchanges.

Precludes transitioning coverage from CHIP to the Exchange without Secretarial certification.

Section 2102 Technical Corrections

Makes a number of corrections to the CHIPRA legislation passed on 2/4/2009. The changes are retroactively effective upon the date of CHIPRA enactment. Changes include:

- Adjustments to CHIP allotments (for FY10) for states with previously approved Medicaid expansions effective January 1, 2006, that provide coverage for children from birth through age 5 in families up to 200 percent of the poverty line;
- A technical correction to lawfully residing immigrants in section 605 of CHIPRA;
- Makes adjustments to the Current Population Survey estimates used to identify "high performing" states under CHIPRA; and
- Ensures that alternative premiums/cost sharing provisions in Medicaid do not supersede premium and cost-sharing protections for Native Americans.

Subtitle C - Medicaid and CHIP Enrollment Simplification

Section 2201 – Enrollment Simplification and Coordination with State Health Insurance Exchanges

Beginning January 1, 2014, as a condition of receiving any FFP for Medicaid, the bill requires states to:

- Establish a process to allow individuals to apply for, enroll in, and renew their enrollment in Medicaid through a website. The website must be linked to the exchange and CHIP. The website must also allow individuals who are eligible for Medicaid and for tax credits in the exchange to compare the available benefits, premiums and cost sharing for each private plan with Medicaid;
- Accept Medicaid and CHIP eligibility determinations made by the exchange, and enroll individuals determined eligible by the exchange without any further determination;
- Determine eligibility and enroll individuals in a health plan through the exchange (without any additional application), and establish eligibility for premium assistance credits, for individuals who apply for Medicaid or CHIP and are determined ineligible. States must also ensure that these individuals receive information about cost-sharing credits;
- Ensure that the exchange, Medicaid and CHIP utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility and enrollment for any of those programs;
- Coordinate medical assistance provided through CHIP or Medicaid with any coverage provided through the exchange, when individuals are enrolled in Medicaid or CHIP and a qualified exchange plan; and
- Conducting outreach and enrollment efforts to venerable populations, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

The bill allows State Medicaid and CHIP agencies to enter into an agreement with an Exchange to determine whether a State resident is eligible for premium assistance tax credits so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

The bill requires State Medicaid agency and State CHIP to participate in and comply with the requirements for streamlined enrollment procedures between Medicaid, CHIP and the Exchange.

Finally, this section clarifies that none of the changes to the eligibility and enrollment procedures would alter state requirements to assess eligibility for HCBS.

Section 2202 – Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Populations

Beginning January 1, 2014, states may permit any hospital participating in Medicaid to determine presumptive eligibility for all Medicaid categories (not just the current groups that allow presumptive eligibility). The presumptive eligibility determinations made by hospitals will have the same requirements that apply to current presumptive eligibility processes. Payments made for medical assistance during the presumptive period are not subject to review for improper payments based upon state eligibility determinations.

Subtitle D – Improvements to Medicaid Services

Section 2301 – Coverage for Freestanding Birth Center Services

The bill establishes care provided in free-standing birth centers as a mandatory Medicaid service. Free-standing birth centers are defined as health centers that are not hospitals, where childbirth is planned to occur away from the pregnant woman's residence, that are licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan, and that comply with any state-defined requirements relating to the health and safety of individuals.

Section 2302 – Concurrent Care for Children in Hospice

In Medicaid and CHIP, if a child elects to receive hospice care, the bill allows continued payment for other Medicaid services, including those that treat the terminal condition.

Section 2303 – State Eligibility Option for Family Planning Services

Creates a new optional eligibility group with a limited service package. Individuals eligible for this group are people who are not pregnant and who have incomes below the highest eligibility level for pregnant women in Medicaid or CHIP; the state also has the option to transition individuals from a family planning waiver to the new optional eligibility group. The service package is limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided as part of family planning services. States can allow presumptive eligibility for individuals through this group. If a state provides presumptive eligibility,

the service package is limited to family planning services and supplies described in section 1905(a)(4)(C) with the option to provide (or not to provide) medical diagnosis and treatment services that are provided as part of family planning services.

Section 2304 – Clarification of Definition of Medical Assistance

Amends the definition of "medical assistance" in Section 1905(a) of the Social Security Act to include both the payment of part or all of the cost of care and services or the care and services themselves, or both.

Subtitle E – New Options for States to Provide Long-Term Services and Supports

Section 2401 – Community First Choice Option

Creates an additional mechanism to provide HCBS through the state plan. States could provide HCBS to individuals eligible under the state plan whose income does not exceed 150 percent of the poverty line, or, for individuals who meet nursing home level of care requirements, up to the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan. States that elect to include the community first choice option would be eligible for a 6% FMAP increase for services provided under the option.

A state that elects to include this option must: establish and collaborate with a development and implementation council; provide these services statewide, in a consumer-directed fashion, and deliver services in the most-integrated setting based upon the individual's needs; maintain or exceed the prior year's level of expenditure for services to people with disabilities and the elderly through 1905(a), 1915, 1115 (or another mechanism) during the first full year of implementation; establish a statewide quality assurance system; and collect and report information that HHS deems necessary to provide oversight and evaluation of the services provided.

Delay in Community First Choice Option. *The Reconciliation Bill Postpones from October 1, 2010 until October 1, 2011 the effective date of the option established for State Medicaid programs to cover attendant care services and supports for individuals who require an institutional level of care*

Section 2402 – Removal of Barriers to Providing Home and Community-Based Services

The legislation requires HHS to promulgate regulations that support flexible, consumer-oriented HCBS services funded by both Medicaid and other sources.

This section also modifies the 1915(i) benefits package that was created by the Deficit Reduction Act. Major changes include:

- The option to simultaneously enroll individuals in 1915(i) and 1915(c)/1115/1915(d)/1915(e) HCBS services;
- Increasing the income limit to 300% of SSI for individuals concurrently enrolled in a 1915(c) waiver;

- Removing the option to limit enrollment in the option;
- Removing the option to waive statewideness;
- Allowing states to waive comparability;
- Removing the option to limit the time period that individuals remain in the benefit after a change to the needs-based criteria. Individuals who lose eligibility due to a change in the criteria would remain eligible for services until they no longer meet the needs based criteria that they were initially admitted though;
- Creating a new optional eligibility group where individuals become Medicaid eligible through the 1915(i) waiver (similar to the special income group for 1915(c) waivers);
- Allowing states to target specific populations and to change the amount, duration and scope of services for different populations. If a state chooses to adopt this provision, it will be effective for five years, with ongoing five-year renewal periods; and
- Adding the "other" services to the allowable benefits packages. States can use "other" to craft flexible benefits packages similar to the option in 1915(c) waivers.

Section 2403 - Money Follows the Person Rebalancing Demonstration

Amends the Deficit Reduction Act of 2005 to: (1) extend through FY2016 the Money Follows the Person Rebalancing Demonstration; and (2) reduce the residential stay requirement from 6 months to 90 days.

Section 2404 – Protection for Recipients of Home- and Community-Based Services Against Spousal Impoverishment

For a five year period beginning on January 1, 2014, states are required to apply the spousal impoverishment rules in Section 1924 of the Social Security Act to individuals in institutions and to individuals in home and community based services provided through sections 1915(c), 1915(d), 1915(i) or 1115 of the social security act. Currently, states are required to apply the spousal impoverishment rules to individuals in institutions and have the option to apply spousal impoverishment rules to individuals in home and community based services. At the end of the five year period, the requirement ends and states will have the option to apply spousal impoverishment to home and community based services.

Subtitle F – Medicaid Prescription Drug Coverage

Section 2501 - Prescription drug rebates

Would apply to managed care organizations. The rebate amounts would be increased with the minimum rebate percentage for single source and innovator multiple source drugs going from 15.1% to 23.1% and from 11% to 13% for generic drugs. The rebate for clotting factors and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications would increase to 17.1 percent.

Drug rebates for new formulations of existing drugs. *Under the Reconciliation Act, for purposes of applying the additional rebate, narrows the definition of a new formulation of a drug to a line extension of a single source or innovator multiple source drug that is an oral solid dosage form of the drug.*

Sec 2502 - Elimination of Exclusion of Coverage of Certain Drugs

Eliminates the exclusion from Medicaid coverage of (thereby extending coverage to) certain drugs used to promote smoking cessation, as well as barbiturates and benzodiazepines.

Sec 2503 -Providing Adequate Pharmacy Reimbursement

This section changes the federal upper limit to no less than 175% of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufactured price.

Subtitle G – Medicaid Disproportionate Share Hospital Payments

Section 2551 Disproportionate Share Hospital Payments

If you are a low DSH state and you have not spent more than 99.90 percent of the DSH allotment for your state on average for the period of fiscal years 2004-2008, as of 9/30/09 your applicable percentage is 25. If you are a low DSH state and you have spent more than 99.90 percent of your DSH allotments on average for the period of fiscal years 2004-2008 as of 9/30/09 your applicable percentage will be 17.5. If you are not a low DSH state and you have not spent more than 99.90 percent of the DSH allotments on average for the period of fiscal years 2004-2008 as of 9/30/09 your percentage will be 50. If you are not a low DSH state and you have spent more than 99.90 percent of the DSH allotments on average for the period of fiscal years 2004-2008 as of 9/30/09 your percentage is 35.

Thereafter the state's DSH allotment would be reduced using a calculation based on further reduction in the rate of uninsured your percentage will differ whether you are a low or high DSH state and whether you have spent more or less than 99.90 percent of your DSH allotment.

If you are a low DSH state and you have not spent more than 99.90 percent of your DSH allotment you will receive a 27.5 percent reduction. If you are a low DSH state and you have spent more than 99.90 percent of your DSH allotment you will receive a 20 percent reduction. If you are not a low DSH state and you have not spent more than 99.90 percent of your DSH allotment you will get a 55 percent reduction and if you are not a low DSH state and you have spent more than 99.90 percent of your DSH allotment you will get a 40 percent reduction.

A state's DSH allotment would not decrease by more than 50% of the allotment in 2012.

Any portion of the state's DSH allotment that is currently being used to expand eligibility through a section 1115 waiver is exempt from the reductions.

Gives Hawaii special rules for their Medicaid Disproportionate Share Hospital (DSH) allotment.

Disproportionate share hospital payments. *The Reconciliation Act lowers the reduction in federal Medicaid DSH payments from $18.1 billion to $14.1 billion and advances the reductions to begin in fiscal year 2014. Directs the Secretary to develop a methodology for reducing federal DSH allotments to all states in order to achieve the mandated reductions. Extends through FY 2013 the federal DSH allotment for a state that has a $0 allotment after FY 2011.*

Subtitle H – Improved Coordination for Dual Eligible Beneficiaries

Section 2601 - 5 year period for Demonstration projects.

This section clarifies the Medicaid demonstration authority for coordinating care for dual eligibles may be as long as five years.

Section 2602 - Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries

Establishes a new office in CMS, the Federal Coordinated Health Care Office for Dual Eligible Beneficiaries. The office would be tasked with improving programmatic and regulatory coordination between Medicare and Medicaid, improving access to services, and increasing dual eligible enrollee satisfaction.

Subtitle I – Improving the Quality of Medicaid for Patients and Providers

Section 2701 Adult Health Quality Measures

The Secretary would create procedures to identify health care quality measurements for Medicaid-eligible adults similar to the procedures already underway for children. The Secretary would also establish procedures for and provide grants to states to collect and voluntarily report health care quality data for Medicaid-eligible adults. The Secretary in consultation with states, would be required to identify specific preventable health care acquired conditions and would prohibit payments for services related to such conditions.

Section 2702 - Payment Adjustment for Health Care-Acquired Conditions

Effective 7/1/11 would prohibit payments to states for Medicaid services related to health care acquired conditions.

Section 2703 – State Option to Provide Health Homes for Enrollees with Chronic Conditions

Establishes a Medicaid state plan option, beginning January 1, 2011, for individuals with chronic conditions to designate a "health home" to coordinate the delivery of their health care. Eligible individuals are people eligible for Medicaid who either have at least 2 chronic conditions; have 1 chronic condition and are at risk for having a second chronic condition; or who have a serious and persistent mental health condition. Chronic conditions will be defined by HHS, but must include: A mental health condition,

substance use disorder, asthma, diabetes, heart disease, or overweight/obesity (as evidenced by having a Body Mass Index over 25).

The health home can be a designated provider, a team of health care professionals operating with such a provider, or a health team, provided that the health home meets standards established by HHS. These could include: physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that meets state and federal requirements to act as a health home.

Services provided by the health home include: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support (including authorized representatives); referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.

For the first 8 quarters that a state establishes this option, it will receive 90% FMAP for those services. After the first 8 quarters, services will be paid at the regular state FMAP. The section establishes planning grants, matched at the state's regular FMAP, to assist states develop an amendment to implement this option. Additionally, HHS is directed to evaluate this program through an independent entity.

Section 2704 - Demonstration Project to Evaluate Integrated Care Around a Hospitalization

Directs the Secretary to establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary: (1) with respect to an episode of care that includes a hospitalization; and (2) for concurrent physicians services provided during a hospitalization.

Section 2705 - Medicaid Global Payment System Demonstration Project

Establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five States that would allow participating States to adjust their current payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure.

Section 2706 - Pediatric Accountable Care Organization Demonstration Project

Establishes a demonstration project that allows qualified pediatric providers to be recognized and receive payments as Accountable Care Organizations (ACO) under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings.

Section 2707 - Medicaid Emergency Psychiatric Demonstration Project

Requires the Secretary of HHS to establish a three-year Medicaid demonstration project in up to eight States. Participating States would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.

Subtitle K – Protections for American Indians and Alaska Natives

Section 2901 – Special Rules Relating to Indians

Requires no cost sharing in the state exchanges for Indians with income at or below 300 % of poverty and health programs operated by the Indian Health Service, Indian tribes, tribal organizations, Urban Indian organizations shall be the payer of last resort for services provided to eligible individuals.

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle B—Increasing Access to Clinical Preventive Services

Section 4101 - School-based health centers. (as modified by Sec. 10402)

Requires the Secretary to establish a program to award grants to eligible entities to support the operation of school-based health centers.

Section 4102 - Oral healthcare prevention activities.

Requires the Secretary, acting through the Director of CDC, to carry out oral health activities, including: (1) establishing a national public education campaign that is focused on oral health care prevention and education; (2) awarding demonstration grants for research-based dental caries disease management activities; (3) awarding grants for the development of school-based dental sealant programs; and (4) entering into cooperative agreements with state, territorial, and Indian tribes or tribal organizations for oral health data collection and interpretation, a delivery system for oral health, and science-based programs to improve oral health.

Requires the Secretary to: (1) update and improve the Pregnancy Risk Assessment Monitoring System as it relates to oral health care; (2) develop oral health care components for inclusion in the National Health and Nutrition Examination Survey; and (3) ensure that the Medical Expenditures Panel Survey by AHRQ includes the verification of dental utilization, expenditure, and coverage findings through conduct of a look-back analysis.

Section 4106 – Improving Access to Preventive Services for Eligible Adults in Medicaid

Beginning January 1, 2013, the state option for diagnostic, screening, preventive and rehabilitation services are expanded to include any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force and adult vaccines recommended by the Advisory Committee on Immunization practices, and the administration of those adult vaccines. States that elect to cover these services, and that do not require cost-sharing for the services, will receive a 1% FMAP increase for preventive services and for the tobacco cessation services described in Sec. 4107.

Section 4107 – Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid

Beginning October 1, 2010, States are required to cover comprehensive tobacco cessation services for pregnant women in Medicaid. Comprehensive tobacco cessation services are defined as diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women. The services are limited to ones recommended for pregnant women in "Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline', published by the Public Health Service (or to any services included in updated versions of that publication). States would not be permitted to require cost-sharing for these services.

Section 4108 - Incentives for Prevention of Chronic Diseases in Medicaid.

Requires the Secretary to award grants to states to carry out initiatives to provide incentives to Medicaid beneficiaries who participate in programs to lower health risk and demonstrate changes in health risk and outcomes.

TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions

Section 6401 - Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP (as modified by Sec. 10603)

Amends Medicare to require the Secretary to: (1) establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP; and (2) determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier.

Requires providers and suppliers applying for enrollment or revalidation of enrollment in Medicare, Medicaid, or CHIP to disclose current or previous affiliations with any provider or supplier that: (1) has uncollected debt; (2) has had its payments suspended; (3) has been excluded from participating in a federal health care program; or (4) has had billing privileges revoked. Authorizes the Secretary to deny enrollment in a program if these affiliations pose an undue risk to it.

Requires providers and suppliers to establish a compliance program containing specified core elements.

Directs the CMS Administrator to establish a process for making available to each state agency with responsibility for administering a state Medicaid plan or a child health plan under SSA title XXI the identity of any provider or supplier under Medicare or CHIP who is terminated.

Section 6402 - Enhanced Medicare and Medicaid program integrity provisions.

Requires CMS to include in the integrated data repository claims and payment data from Medicare, Medicaid, CHIP, and health-related programs administered by the Departments of Veterans Affairs (VA) and DOD, the Social Security Administration, and IHS.

Directs the Secretary to enter into data-sharing agreements with the Commissioner of Social Security, the VA and DOD Secretaries, and the IHS Director to help identity fraud, waste, and abuse.

Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later.

Directs the Secretary to issue a regulation requiring all Medicare, Medicaid, and CHIP providers to include their National Provider Identifier on enrollment applications.

Authorizes the Secretary to withhold the federal matching payment to states for medical assistance expenditures whenever a state does not report enrollee encounter data in a timely manner to the state's Medicaid Management Information System.

Authorizes the Secretary to exclude providers and suppliers participation in any federal health care program for providing false information on any application to enroll or participate.

Subjects to civil monetary penalties excluded individuals who: (1) order or prescribe an item or service; (2) make false statements on applications or contracts to participate in a federal health care program; or (3) know of an overpayment and do not return it. Subjects the latter offense to civil monetary penalties of up to $50,000 or triple the total amount of the claim involved.

Authorizes the Secretary to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question.

Requires the Secretary take into account the volume of billing for a durable medical equipment (DME) supplier or home health agency when determining the size of the

supplier's and agency's surety bond. Authorizes the Secretary to require other providers and suppliers to post a surety bond if the Secretary considers them to be at risk.

Authorizes the Secretary to suspend payments to a provider or supplier pending a fraud investigation.

Appropriates an additional $10 million, adjusted for inflation, to the Health Care Fraud and Abuse Control each of FY2011-FY2020. Applies inflation adjustments as well to Medicare Integrity Program funding.

Requires the Medicaid Integrity Program and Program contractors to provide the Secretary and the HHS Office of Inspector General with performance statistics, including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment for such activities.

Section 6403 - Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.

Requires the Secretary to furnish the National Practitioner Data Bank (NPDB) with all information reported to the national health care fraud and abuse data collection program on certain final adverse actions taken against health care providers, suppliers, and practitioners.

Requires the Secretary to establish a process to terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in it is transferred to the NPDB.

Subtitle F—Additional Medicaid Program Integrity Provisions

Section 6501 - Termination of provider participation under Medicaid if terminated under Medicare or other State plan.

Amends Medicaid to require states to terminate individuals or entities (providers) from their Medicaid programs if they were terminated from Medicare or another state's Medicaid program.

Section 6502 - Medicaid exclusion from participation relating to certain ownership,control, and management affiliations

Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that:

1. Has failed to repay overpayments during a specified period;
2. Is suspended, excluded, or terminated from participation in any Medicaid program; or
3. Is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

Section 6503 - Billing agents, clearinghouses, or other alternate payees required to register under Medicaid

Requires state Medicaid plans to require any billing agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers to register with the state and the Secretary.

Section 6504 - Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.

Requires states to submit data elements from the state mechanized claims processing and information retrieval system (under the Medicaid Statistical Information System) that the Secretary determines necessary for program integrity, program oversight, and administration.

Requires a Medicaid managed care entity contract to provide for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients (as under current law) at a frequency and level of detail to be specified by the Secretary.

Section 6505 – Prohibition on payments to institutions or entities located outside of the United States

Requires a state Medicaid plan to prohibit the state from making any payments for items or services under a Medicaid state plan or a waiver to any financial institution or entity located outside of the United States.

Section 6506 – Overpayments

Extends the period for States to repay overpayments to one year when a final determination of the amount of the overpayment has not been determined due to an ongoing judicial or administrative process. When overpayments due to fraud are pending, State repayments of the Federal portion would not be due until 30 days after the date of the final judgment.

Section 6507 - Mandatory State use of national correct coding initiative

Requires state mechanized Medicaid claims processing and information retrieval systems to incorporate methodologies compatible with Medicare's National Correct Coding Initiative.

Section 6508 - General effective date

Except as otherwise provided, the effective date for Subtitle F (Additional Medicaid Program Integrity Provisions) is January 1, 2011, with a delay if state legislation is necessary. If legislation is necessary, states must come into compliance by the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment (The bill was enacted on March 23, 2010).